State of Idaho, Division of Medicaid

INTRANASAL RHINITIS AGENTS

PRIOR AUTHORIZATION FORM

CONFIDENTIAL INFORMATION

Phone: 1-208-364-1829 *One drug per form ONLY – Use black or blue ink* **Fax: 1-208-364-1864**

Patient Name: _____ Medicaid ID#: _____ D.O.B.: _____

Prescriber Name: _____ State License #: _____ Specialty: _____

Prescriber Phone: _____ Prescriber Fax: _____

Pharmacy/Store#: Phone: Fax:

Astelin®, Nasacort AQ®, Nasonex®, fluticasone, and ipratropium nasal spray are preferred agents and will be approved for payment without prior authorization for eligible participants within the approved dosage quantities and age limits.

Atrovent® , Beconase AQ®, Nasarel®, flunisolide, and Rhinocort Aqua® will be approved for payment only after documented failure of 1(one) preferred agent.

Medication Requested:

Astelin®	**NO PA REQUIRED**	**fluticasone**	**NO PA REQUIRED**
Nasacort AQ®	**NO PA REQUIRED**	**ipratropium nasal spray**	**NO PA REQUIRED**
Nasonex®	**NO PA REQUIRED**		

Drug	Strength	Dosing Instructions
☐ Atrovent®		
☐ Beconase AQ®		
☐ Nasarel®		
☐ flunisolide		
☐ Rhinocort Aqua®		

History of preferred agent:

Drug	Dates of Trial	Reason(s) for Failure

Other pertinent information for review:

_____

_____

To ensure continuity of care, please make sure corresponding ICD-9 codes are submitted on professional office claims to Idaho Medicaid on a routine basis.

Prescriber Signature: _____ **Date:** _____

By signing, the prescriber agrees that documentation of above indication and medical necessity is available for review by Idaho Medicaid in patient's current medical chart.

For Medicaid Office Use Only

Date: RPh: Tech: PA#:

Approved Denied Comments:

All current PA forms and criteria for use are available at: www.medicaidpharmacy.idaho.gov (PA Criteria & Forms)

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